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ABSTRACT

The revision of the psychiatric profession's diagnostic taxonomy, the "Diagnostic and Statistical Manual," also known as "DSM III," is underway. The process will result in the publication of "DSM-IV." Those involved in the revision seek both to make as few changes as possible and to satisfy an entire field. The Revision Task Force must convince mental health professionals that the DSM-IV is an improvement over the DSM-III and a previous revision known as DSM-R. Task force leaders seek to convince their profession, in a series of journal articles, that while the DSM-IV will leave the previous editions mostly unchanged, it will also be more empirically based than the earlier versions. At the same time, the leaders seek to place their work in line with past editions by using empiricist language to describe the development of all three manuals. The aim of the narratives is to argue that the major innovation of the new edition is not surprising new content, but rather, the systematic nature of the revision process. Observations of the revision process in one subcommittee suggested that the process does in some ways match the representations of it by task force leaders as more open, explicit, and empirical than previous ones. However, further data analysis may show that the DSM-IV process is more like the earlier revision processes than task force accounts would have the mental health community believe. An appendix presents contrasting excerpts from DSM-III-R and DSM-IV. (SG)

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Intertextuality in Psychiatry:

Revising the DSM-III Charter

I want to tell you this afternoon about the revision of the most important book in the mental health profession--its charter document, a 500-page diagnostic taxonomy, the Diagnostic and Statistical Manual, often referred to as DSM-III. For two years my collaborator, Dr. Joan Gerring, a child psychiatrist, and I have observed this revision process which is sponsored by the American Psychiatric Association. The revision of the DSM manual is a five year project, involving some 1000 mental health professionals and costing hundreds of thousands of dollars. It will culminate next year with the publication of DSM-IV.

Although recent studies in composition have focused on the revision of other types of scientific texts, none has yet examined the special difficulties for a field when it revises its charter. Dr. Gerring and I have found the revision of the DSM to be unusual for two reasons. First, because the DSM charter profoundly influences ongoing research and clinical practice, even the smallest alterations are perceived as being potentially disruptive. Thus, we found that, unlike many revisions, the object of this one is to make as few changes as possible. Second, this revision is unusual because it must satisfy an entire field. Revision Task Force leaders must sell DSM-IV to the mental health profession, a heterogeneous field comprised of multiple, competing disciplines. Because of this diverse audience and because of the significance of the DSM

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charter, DSM-IV Task Force leaders could not rely on the arguments usually made for introducing new texts into a scientific literature. That is, they could not criticize the exiting literature, in this case the DSM-III, as being mistaken, inconsistent, or incomplete because to do so would call into question the credibility of the profession itself whose ways of knowing the charter encodes. As a result Task Force leaders had to devise unusual arguments for convincing their peers to accept the DSM revision. It is these rhetorical strategies, strategies employed by Revision Task Force leaders to sell the DSM-IV to their field, that I want to tell you about today.

First, however, let me describe the book I am calling a charter document for mental health. The third edition of the Diagnostic and Statistical Manual, DSM-III, was published by the American Psychiatric Association in 1980 in response to a lack of diagnostic reliability within the field. Before 1980 there were no standardized definitions of mental disorders. Schizophrenia, for example, meant something different in New York than it did in Baltimore or London. DSM-III was created by the American Psychiatric Association to provide a common classification system, a common language to facilitate clinical and research conversations. In this manual some 250 mental disorders are named, described, and defined with specific operational criteria. In the eleven years since its publication, DSM-III and its first revision, DSM-III-R which came out in 1987, have sold more than one million copies worldwide. This taxonomy of mental disorders is now used not only by psychiatrists but by professionals in related mental health and medical fields, and in government, insurance, and legal agencies.

Let me show you how the DSM works. On page 1 of your handout (attached) you have the diagnostic criteria for two eating disorders, anorexia nervosa and bulemia

nervosa. In order to be diagnosed anorexic a person must fulfill all four criteria; to be diagnosed bulemic, a person must fulfill five. These criteria are the observable clinical features of the disorder which must be present if the diagnosis is to be made. Notice that DSM-III does not include in its criteria speculations about causation because so little is yet known about the actual causes of most mental disorders. Neither does DSM-III recommend treatment. Rather, it attempts to describe comprehensively the manifestations of mental disorders.

I'd like to return now to the rhetorical strategies I mentioned at the beginning of my talk, that is, the rhetorical strategies Revision Task Force leaders have used to sell their revision, the DSM-IV, to the field. This finding from Dr. Gerring's and my study focuses on intertextuality, specifically the relationship of DSM-IV to its predecessor manuals, DSM-III and III-R. Now in most academic and professional communities, when writers want to contribute new knowledge, they employ certain rhetorical strategies to persuade their colleagues of its value, to persuade them that a place should be made for the new knowledge in the field's literature. However, as I said before, Revision Task Force leaders faced a more complicated selling job than most because of the significance of the charter document and because of the diverse audience it must satisfy.

How do they do this? How do Task Force leaders persuade the field that DSM-IV will be an improvement over DSM-III and III-R? In seven articles appearing in prominent journals in psychiatry and psychology between 1989 and 1991, Task Force Leaders create two narratives which position DSM-IV in relation to its predecessors. These two narratives reassure the field that actual changes in the charter will be minimal, and then they move away from the revised product

to focus on the revision process. In both narratives Task Force leaders describe the process which will result in DSM-IV as being more empirical than the processes which produced DSM-III and III-R. In the first narrative, which we call the Contingent Repertoire Story, Task Force leaders say that the committees which produced III and III-R may have made "arbitrary" and "whimsical" decisions about the definitions of disorders, decisions too much reflecting committee members' biases. In any case, they add, these earlier committees' deliberations were not documented, nor were they submitted to discipline-wide critique. By contrast, Task Force leaders say, the process for constructing DSM-IV is more open and more rigorously empirical. All changes proposed by the workgroups will be supported by empirical evidence and documented in published literature reviews. The DSM-IV process, instead of being "arbitrary" and "whimsical," will be <quote> "objective," "systematic," "unbiased," and "explicit." This empiricist language is intended to convince readers that DSM-IV will be acceptable to all professionals who value a scientific approach, who value, as Task Force leaders put it, <quote> "a quiet consideration of evidence rather than loud expressions of personal views."

But to criticize the development of DSM-III and III-R too harshly is dangerous for Task Force Leaders because they are attempting to assure the field that much of DSM-III-R will remain unchanged in DSM-IV. Furthermore, in criticizing the way the earlier manuals were developed, Task Force leaders may cast doubt upon their own authority. Not only were many of them actually involved in the production of III and III-R, these documents are the foundations of more than a decade of mental health treatment and inquiry. Because of these considerations, Task Force leaders also tell a second story, a story which creates yet another version of the relationship between DSM-IV and its

predecessors.

In the second story--which we call the Progress of Science account--Task Force leaders place themselves in a direct line with DSM-III and III-R by using empiricist language to describe the development of all three manuals. In the Progress of Science account, responsibility for shortcomings in the development of DSM-III and III-R is shifted to the state of mental health science in 1980 and 1987 and away from contingent forces like personal bias and failure to provide documentation. This second story presents DSM-IV's predecessors as having had, "by necessity," to work with mere expert opinion. Now, however, thanks in large part to these two earlier documents, there is much more empirical data about mental disorders upon which DSM-IV workgroups can draw. Thus, according to the Task Force's second account, DSM-III and III-R were not wasteful false moves in mental health's increasing adoption of empirical methods, but the best that could be done under the circumstances. In this story, DSM-IV inherits the fruits of ten years of research stimulated by III and III-R, fruits which are depicted as part of the inevitable advance of mental science. The Progress of Science account concludes by projecting the profession into the future, to a time when research will have rendered DSM-IV obsolete. Task Force leaders write, "We can look forward to future diagnostic systems based not, as at present, on superficial descriptive similarities, but on an understanding of causal mechanisms. These systems will be both more elegantly clear and more powerfully predictive." DSM-IV is presented as indespensible in bringing about this goal, a goal which Task Force leaders believe all their readers can support.

As Dr. Gerring and I examine these accounts, we ask, Just how persuasive to the field are these narratives? Who's buying? Who's not? and What will be their effects? We believe that Task Force leaders are astute in their decision

to argue in their two narratives that the major innovation of the revision is not surprising new content but, rather, the systematic nature of the revision process. Scientific method is, at this moment in the profession's history, a powerfully persuasive umbrella under which competing disciplines and perspectives can meet. DSM-IV will certainly be approved and adopted into worldwide use next year, and these narratives will have played an important role. In addition, these stories will reap political benefits for psychiatry. They will solidify the dominance of psychiatry over it neighboring disciplines within mental health such as psychology and social work. They will also enhance psychiatry's prestige in relation to other medical specialties, specialties which have, historically, viewed psychiatry as a lesser occupation, as being engaged merely in theoretical speculations, not science. Thus, Dr. Gerring and I believe that the Selling of DSM-IV is not only about revising psychiatry's charter document; it is also about reconstructing psychiatry's place in health care. As psychiatry revises its charter, it is revising its definition of itself.

Let me now give you a glimpse into the naturalistic data Dr. Gerring and I have collected over the past two years as we have observed the revision process in one subcommittee, a workgroup comprised of five psychiatrists and one psychologist which is responsible for the eating disorders. As we further analyze our data this summer, one of our central questions will be How does the workgroup process we observed square with the Task Force leaders' published representations of it? Was the process actually more "objective," "systematic," "unbiased," and "explicit" than previous processes? I'll describe two ways in which it appeared to be.

First, in an effort to convince the field that proposed revisions to the charter are the result of a systematic and explicit process and not of committee

bias or hidden political agendas, the American Psychiatric Association last summer published what it calls the Options Book. In this book all proposed changes to the manual are presented along with the workgroups' reasons for suggesting them, and input from the field is invited. Soliciting discipline-wide critique of proposed revisions before they are adopted will, according to Task Force leaders, help guarantee that the manual represents a consensus of knowledge within the field.

Beginning on page 2 of your handout, you will see the options for revision proposed by the Eating Disorder Workgroup. Please look at page 2 and note the typography. The italicized paragraph below the words Anorexia Nervosa summarizes the workgroup's thinking about this disorder, and in the four criteria, A through D, the workgroup's suggested additions are indicated by boldface, and their suggested deletions are indicated by crossings-out. Similarly, on pages 3 and 4 of your handout, the workgroup suggests revisions in the definition of bulemia. This typography represents an attempt to show that these definitions do not yet have official status, that they are still in process, and that revision committees are still open to additional evidence from the field.

In addition to the Options Book, a second segment of Dr. Gerring's and my data also corroborates Task Force leaders' story about the more open and empirical nature of the DSM-IV process. In fact, at one Workgroup meeting in the summer of 1990, Dr. Gerring and I watched a conflict that seemed to reinact the intertextual relationship between DSM-IV and its predecessors as described in the Contingent Repertoire account. This Workgroup drama pitted two very powerful men against one another: Robert Spitzer, who headed the development of DSM-III and DSM-III-R, against Allen Frances, the chief of DSM-IV. As a result of this

exchange, Spitzer adjusted his DSM-III procedures to conform to the new rules of the DSM-IV process, a process which allegedly privileges empirical research. In this 1990 meeting Spitzer proposed to the Workgroup that a new disorder be added to DSM-IV. You will find this new disorder on page 5 of your handout: Binge Eating Disorder or BED. Spitzer argued that Binge Eating Disorder should be included in DSM-IV, even though there is yet little research on it, because many experts know it exists out there in a sub-group of the obese population. Several workgroup members agreed with Spitzer that BED may exist out there, but they worried that to include this particular definition of it in DSM-IV would be to reify it too soon. Spitzer responded by reminding them that when he included bulemia in DSM-III in 1980, it too was brand new. And including it then had been a good thing; it made treatment reimbursible and generated the research necessary to define the disorder more accurately. To this Allen Frances replied, "That was 1980 when things were wide open. It's different now. Research must come first." After several more exchanges in which Spitzer argued strongly for the usefulness of Binge Eating Disorder, Frances concluded by saying, "Bob, I like you. I like your disorder. In fact, at times I even have your disorder. But we won't put it in DSM-IV unless you can convince us with research. And I don't think you've got time before publication to do that."

In spite of Allen Frances' skepticism, Robert Spitzer, along with several other proponents of Binge Eating Disorder, are conducting research to establish its validity. As this drama shows, Spitzer modified his DSM-III approach in order to operate within new constraints imposed by the DSM-IV process. The fate of BED will be decided in the fall when the Workgroup votes on it. After that, Allen Frances and Task Force leaders will have the last word, and they claim that their requirements for including new diagnoses will be very high. Frances told

us he fears that a proliferation of new disorders could undermine the credibility of the entire DSM enterprize. And this new disorder, BED, is particularly tricky because it is the first time that any part of the obese population has been considered for a psychiatric diagnosis.

These two areas of Dr. Gerring's and my data suggest that the process we observed does in some ways match the representations of it created by Task Force leaders to sell the revision to the field. The process does indeed at points seem more open, explicit, and empirical than previous ones. However, we also found that social and political considerations still play a large role. As Dr. Gerring and I further analyze our data this summer, I suspect we will conclude, contrary to Task Force leaders' claims, that the DSM-IV process is actually more like the earlier processes than their accounts of it would have us believe.

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From Diagnostic and Statistical Manual of the
American Psychiatric Association
(DSM - III - R, 1987)

Diagnostic criteria for 307.10 Anorexia Nervosa

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Diagnostic criteria for 307.51 Bulimia Nervosa

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight.

from DSM-IV Options Book: Work in Progress, 1991.

Eating Disorders

Washington, DC: American Psychiatric Assn. Press

Note: The following conventions are used to indicate proposed changes from DSM-III-R: **bold** text indicates proposed new wording; ~~crossed-out~~ text indicates DSM-III-R wording suggested for omission. The reader should keep in mind that retaining the existing DSM-III-R criteria is always an option.

F50.0 Anorexia Nervosa

DSM-III and DSM-III-R adopted different conventions in defining the relationship between Anorexia Nervosa and Bulimia Nervosa. In DSM-III, the diagnosis of Bulimia Nervosa could not be made if it were judged that the "bulimic episodes were...due to Anorexia Nervosa." In contrast, in DSM-III-R, individuals who met criteria for both disorders were given both diagnoses. This approach has the advantage of saving information that was lost in DSM-III, but it may result in the misleading implication that the individual has two independent disorders. It is therefore proposed that, in DSM-IV, Anorexia Nervosa be subtyped according to the presence or absence of symptoms of bulimia and that the diagnosis of Bulimia Nervosa not be given in the presence of Anorexia Nervosa. This proposal for subtyping is supported by data that individuals with Anorexia Nervosa who have bulimic symptoms tend to be heavier and to have more lability of mood, impulsivity, and drug abuse. Another proposed change is to clarify the nature of the individual's disturbance in body perception as defined in criterion C.

A. Refusal to maintain body weight over a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight 15% below that expected), or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight size~~,~~ or shape is experienced, **undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.** ~~e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight~~

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her period occurs only following hormone, e.g., estrogen administration.)

Specify **type:**

Bulimic type: During the episode of Anorexia Nervosa, the person engages in recurrent episodes of binge eating.

Nonbulimic type: During the episode of Anorexia Nervosa, the person does not engage in recurrent episodes of binge eating.

F50.2 Bulimia Nervosa

Three issues have been considered in the definition and subtyping of Bulimia Nervosa: 1) the definition of a binge, 2) the role of purging behaviors, and 3) the relationship between Anorexia Nervosa and Bulimia Nervosa.

The proposed definition of a binge in DSM-IV would include what in DSM-III-R was separated into two criteria: A (i.e., excessive eating) and B (i.e., sense of lack of control over eating). This would not change the definition of caseness but would bring the definition of binge eating into conformity with clinical usage.

The DSM-III-R definition of Bulimia Nervosa requires that the person regularly engage in behaviors to compensate for the effects of the binge eating. DSM-III-R includes a wide range of such compensatory behaviors (i.e., self-induced vomiting, the use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise). This definition may result in a heterogeneous definition of Bulimia Nervosa that does not correspond to the narrow definition used in many research studies that restrict the diagnosis to those individuals who regularly engage in purging behavior. Two options for change have been proposed. One option would retain the current DSM-III-R criterion but add a subtyping scheme to allow the clinician to distinguish those individuals who purge from those who do not. A second option is to narrow the definition of Bulimia Nervosa by restricting the diagnosis to those individuals who regularly purge after binge eating.

Finally, it is proposed that individuals who meet criteria for Bulimia Nervosa only as part of the clinical presentation of Anorexia Nervosa not be given a comorbid diagnosis of Bulimia Nervosa, but rather be given the diagnosis of Anorexia Nervosa, Bulimic Type. If the subtyping scheme suggested above for Anorexia Nervosa is adopted, an exclusionary criterion (item E) would be added to Bulimia Nervosa. This exclusionary criterion only precludes a comorbid diagnosis of Anorexia Nervosa and Bulimia Nervosa when the binge eating occurs during the Anorexia Nervosa. An individual can still be given a diagnosis of Bulimia Nervosa if binge eating occurs at times when criteria for Anorexia Nervosa are no longer met. Such a person would have a diagnosis of current Bulimia Nervosa, and Anorexia Nervosa, in Full Remission.

A. **Recurrent episodes of binge eating. ~~(rapid consumption of large amount of food in a discrete period of time)~~ An episode of binge eating is characterized by both of the following:**

(1) **eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat in a similar period of time**

(2) **a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating) ~~A feeling of lack of control over eating behavior during the eating binges.~~**

(Cont. next page)

Bulemia Nervosa (con't.)

Eating Disorders

Criterion B: Options for compensatory behavior

Option B1: Restrict to vomiting or use of laxatives

B. The person regularly engages in either self-induced vomiting or the use of laxatives ~~or diuretics, strict dieting or fasting, or vigorous exercise~~ in order to prevent weight gain.

Option B2: No change from DSM-III-R criterion but with the addition of purging and nonpurging subtypes

C. A minimum average of two binge-eating episodes a week for at least three months.

D. **Self-evaluation is unduly influenced by body shape and weight.** Persistent ~~overconcern with body shape and weight~~

E. **The disturbance does not occur exclusively during episodes of Anorexia Nervosa.**

Specify **type:** *(applies to Option #2 above)*

Purging type: if person regularly engages in self-induced vomiting or the use of laxatives or diuretics.

Nonpurging type: use of strict dieting, fasting, or vigorous exercise, but does not regularly engage in purging.

F50.8 Binge Eating Disorder (BED)

It has been suggested that there are individuals who have serious distress or impairment consequent to binge eating but who do not qualify for the diagnosis of Bulimia Nervosa because they do not engage in compensatory behaviors (e.g., purging). A multisite study is attempting to provide additional information about the reliability, prevalence as assessed by clinical interview, and the clinical utility of this proposed diagnosis. If insufficient evidence is available to justify its inclusion as a separate category in DSM-IV, it could be provided as an example of Eating Disorder NOS (see below, example [2][a]) and the proposed criteria set could be included the Appendix.

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat in a similar period of time

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. During most binge episodes, at least three of the following behavioral indicators of loss of control are present:

(1) eating much more rapidly than usual

(2) eating until feeling uncomfortably full

(3) eating large amounts of food when not feeling physically hungry

(4) eating large amounts of food throughout the day with no planned mealtimes

(5) eating alone because of being embarrassed by how much one is eating

(6) feeling disgusted with oneself, depressed, or feeling very guilty after overeating

C. The binge eating occurs, on average, at least twice a week for a six-month period.

D. The binge eating causes marked distress.

E. Does not occur exclusively during the course of Bulimia Nervosa and the individual does not abuse medication (e.g., diet pills, thyroid medication) in an attempt to avoid weight gain.

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